

Patient History Form

Thank you for considering Acupuncture! On your first visit, we will need you to:

1). Complete all 4 pages, sign and date. 2). We may need a copy of your insurance card. (optional)

Name: _____ Phone: _____ Date: _____

Address: _____ City: _____ State: _____ ZIP: _____

Ht: _____ WT: _____ Age: _____ Date of Birth: _____ Marital Status: _____

Home phone: _____ Work/Cell phone: _____

Email address (optional): _____

Occupation: _____ Employer: _____ Phone: _____

Emergency contact's name and phone: _____

Family Physician's name and phone: _____

INSURANCE INFORMATION:

Does your insurance cover Acupuncture? ___ No ___ Yes. If yes, we will need a copy of your card.

Insurance Co.: _____ Phone: _____ Insured's Name: _____

Group/Policy #: _____ ID/SS#: _____

TREATMENT GOALS:

What is the main condition you would like to address?

Does this affect sleep, work, other? _____

How long have you had this condition? _____

What diagnosis, if any, have you been given? _____

What treatments have you tried (list physician, date, results)? _____

Would you consider taking a herb formula? _____

HEALTH HISTORY:

Current medications (list): _____

Are you taking blood thinners? _____

Are you/might you be currently pregnant? _____

Do you have any implants/pacemaker? _____

Are you allergic to sulfur? _____

PAST MEDICAL HISTORY:(check all that apply)

- | | | | |
|-----------------------|---------------------------|----------------|----------------|
| _____ Allergies | _____ Hepatitis | _____ Seizures | _____ Cancer |
| _____ Diabetes | _____ Heart Disease | _____ Surgery | _____ HIV |
| _____ Stroke | _____ High Blood Pressure | | _____ Epilepsy |
| _____ Thyroid Disease | | | |

Other: _____

Surgery History: _____

List previous accidents/injuries/major illnesses: _____

LIFESTYLE: (circle yes or no)

Do you exercise regularly? Y / N _____

Do you smoke? Y / N _____ If yes, how much? _____

Do you drink alcohol? Y / N _____ If yes, how much? _____

How much coffee/tea/soda do you drink per day? _____

How much water do you drink per day? _____

How often do you eat the following:

- | | | | | |
|------------------|-----------------|-------------|--|-------------|
| vegetables _____ | candy _____ | dairy _____ | red meat _____ | chips _____ |
| fruit _____ | fast food _____ | | refined carbs (bread, pastries...) _____ | |

Supplements: _____

Check All That Apply:

Energy level:

low energy low energy after exercise lethargic
 SOB sleepy during the day reluctant to talk
 fatigue catch colds easily

Circulation/blood:

dizziness bleeding nose bleeds floater/spots
 numbness/tingling in extremities

Lung & Associated TCM functions

cough dry sputum fever & chills
 nose bleeds dry mouth dry skin dry throat
 sinus congestion dry nose sneezing overall achy body
 sore throat feeling sad allergies difficulty breathing
 smoke cigarettes melancholy
 headaches: how often? _____

Spleen & Associated TCM functions

low appetite abdominal gas abdominal bloating bruise easily
 crave sweets hemorrhoids gurgling stomach nose bleeds
 worry over thinking pensive loose stools
 urgent BMs diarrhea constipated weight gain
 discomfort after BM blood in stool mucus in stool
 feel tired after eating undigested food in stool

Number of bowel movements per day _____

Prolapsed organ. If so, which organ and when _____

Dampness:

general feeling of heaviness in body mental fogginess mental sluggishness
 nausea chest congestion vaginal discharge overweight
 swelling. If so, where: _____

Stomach & Associated TCM Functions:

heart burn mouth sores pain after eating large appetite
 bleeding, painful or swollen gums facial swelling/pain vomiting
 bad breath acne acid regurgitation belching
 hiccups stomach pain

Liver/Gallbladder & Associated TCM Functions:

alternating diarrhea and constipation high stress level bitter taste in mouth
 bad temper headaches anger easily irritable
 heat in head/face muscle tension frustration
 lump in throat muscle twitches depression feel tense
 gall stones itchy skin/rashes high pitch ringing in ears
 itch/pain in genitals seizure/convulsions

_____ discomfort/tightness/tension around ribcage
_____ sexually transmitted disease _____

Eyes:

_____ itchy _____ blood shot _____ dry _____ watery _____ blurred vision
_____ poor vision _____ poor vision _____ eyes feel hot at night

Heart and Associated TCM Functions:

_____ palpitations _____ irregular heart beat _____ pacemaker _____ insomnia
_____ poor sleep _____ chest pain _____ mental confusion _____ anxiety
_____ chest pain arm to shoulder _____ restlessness
_____ sore on tip on tongue

Kidney and Associated TCM Functions:

_____ low back pain/weakness _____ weak or sore knees _____ cold sensation in low back
_____ cold sensation in knees _____ wake at night to urinate _____ kidney stones
_____ bladder/kidney/urinary infection _____ memory problems
_____ lack of bladder control _____ feel fearful _____ excessive hair loss/balding
_____ easily startled _____ frequent broken bones _____ frequent cavities
_____ Libido _____ normal _____ high _____ low

Urination:

_____ normal color _____ reddish _____ with blood _____ dark yellow
_____ clear _____ cloudy _____ scanty _____ scanty
_____ profuse _____ painful _____ dribbling _____ urgent
_____ difficult _____ other: _____

For Women ONLY:

Are you pregnant: _____ Age of first period: _____ Number of pregnancies: _____
Number of live births: _____ Are you having or have had difficulty conceiving? _____
Are your menses regular or irregular? _____ Is your flow heavy or light? _____
How many days does your period last? _____ How many days between periods? _____
Do you experience any of the following symptoms before or during your period?
_____ abdominal cramps _____ food cravings _____ breast tenderness/swelling
_____ headaches/migraines _____ depression _____ moodiness
_____ dull pain _____ sharp pain

For Men ONLY:

Do you experience any of the following?
_____ swollen testes _____ testicular pain _____ impotence
_____ coldness or numbness in genitalia

Other: _____

Patient's Signature

Date